

FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

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We are pleased to offer a Flexible Benefits Plan ("Plan"). Under federal tax laws, the Plan is also called a "cafeteria plan." This Summary Plan Description ("Summary") describes the basic features of the Plan and how it operates. This is only a summary of the key parts of the Plan and it is not part of the plan document. If there is a conflict between the plan document and this Summary, the plan document will control.

PART 1 ADMINISTRATIVE INFORMATION

Name of the Plan City of Tempe Flexible Benefits Plan

Effective Date Original – January 1, 1985
Amended and Restated - July 1, 2003

Company City of Tempe
20 6th Street
Tempe, AZ 85281
EIN: 86-6000262 (480) 350-8279

The Company is the Plan Sponsor. The Company Representative will be Human Resources. You should contact the Company Representative if you have any questions concerning the Plan or this Summary.

Administrator City of Tempe
20 6th Street
Tempe, AZ 85281
EIN: 86-6000262 (480) 350-8279

Plan Number 501

Plan Year July – June. Plan records are kept on a plan year basis.

Coverage Year For the pre-tax premium benefit, the Coverage Year for each Covered Program is the annual period of coverage for that Covered Program. The Coverage Year for the medical expense reimbursement benefit is the same as the Plan Year. The dependent care reimbursement benefit is the Calendar Year.

Legal Agent City of Tempe

PART 2 GENERAL INFORMATION

Questions & Answers

2.1 What benefits does the Plan provide?

The Plan has 3 types of non-taxable benefits: pre-tax premium payments, medical expense reimbursement and dependent care reimbursement. As indicated in the following Parts to this Summary, each benefit has a limit with respect to the amount that you may elect for any Coverage Year. In addition, the total amount of benefits elected under the Plan may not exceed the sum of \$7,000 plus the cost of elected pre-taxed premiums. In lieu of these benefits, you may receive a cash benefit (the amount of which will be included in your gross income and taxable) by electing not to reduce your regular salary.

2.2 When am I eligible to participate in the Plan?

All regular employees who complete 30 days of employment are eligible to participate in the Plan. This includes City of Tempe Councilman and Mayor. Individuals providing services to the Employer as an independent contractor or any “self-employed individual” as described in Code Section 401(c) are not eligible.

Once you meet the eligibility requirements, your Entry Date is the first of the following month, provided that you enroll in the Plan. (See Answer 2.3 below.) Those employees who actually participate in the Plan are called “Participants.” In general, once you become a Participant, you will continue to participate until you choose to stop participating, you no longer meet the eligibility requirements, or you are no longer employed by the Company. (See Answer 2.4 for more detail on your ability to discontinue participation in the Plan.)

2.3 When can I enroll?

When you first become eligible, you will have an opportunity to enroll in the Plan. This period of time is your Initial Enrollment Period. If you do not enroll during your Initial Enrollment Period, you will have to wait until the Annual Enrollment Period to enroll. (But see Answer 2.4 for when changes are allowed during a Coverage Year.) The Annual Enrollment Period is the period of time prior to the beginning of each Coverage Year, during which you will have an opportunity to change your elections for the next Coverage Year.

If you do not change your election during the Annual Enrollment Period, your current election for the pre-tax premium benefit will remain in place for the next Coverage Year, but your medical expense and/or dependent care reimbursement benefits will end and you will not have these benefits for the next Coverage Year.

2.4 Can I change my election during a Coverage Year?

Generally, you cannot change your election during a Coverage Year. There are, however, certain, limited circumstances under which you can change your election during a Coverage Year. If one of the following events occurs, you can make a change in election within 30 days after the event occurs:

- your marriage, divorce, legal separation, or annulment or your spouse's death;
- the birth, adoption, placement for adoption, or death of your child;
- a change in your child's age or student status or other change affecting your child's eligibility for coverage;
- a change in your or your spouse's or child's employment status (for example, starting or ending employment, starting or ending an unpaid leave of absence, or increasing or decreasing hours worked); or

If your unpaid leave is a family medical leave or military leave, special rules may apply to you, and you should ask the Administrator for more details.

- a change in your or your spouse's or child's residence.

To change your health coverage, however, the event must affect your, your Spouse's or your child's eligibility for coverage (*i.e.*, a gain or loss) and your change in election must be consistent with the gain or loss.

If the Company notifies you that one of the following events has happened, you will have 30 days to make a change in election:

- a significant increase in the cost of your elected coverage under one or more Covered Programs;
- a significant decrease in the cost of coverage available under one or more Covered Programs;
- an addition of a new coverage option or a significant improvement of an existing option; or
- a significant decrease in benefits provided under your elected coverage under one or more Covered Programs.

(See Answer 3.2 for the definition of Covered Program.)

You also can make a change in election for dependent care reimbursement benefits if there is a significant increase or decrease in the cost or a significant improvement or decrease in the dependent care reimbursement benefits, provided that you make your change in election within 30

days of when the change occurs. A change in election for medical expense reimbursement benefits is not allowed under these circumstances.

If one of the following events occurs during a Coverage Year, you can change your election under the Plan to adjust your pre-tax withholdings to an amount needed to pay for newly elected coverage under the Company's health plan:

- you are adding coverage under the Company's health plan:
 - for your child because of a court order requiring you to provide health coverage for your child; or
 - for an individual (who is yourself or your spouse or child) because that individual loses coverage under Medicare, Medicaid, or certain group health plans provided by a governmental or educational institution.
- you are dropping coverage under the Company's health plan:
 - for your child because of a court order requiring your spouse (or former spouse) to provide health coverage for your child; or
 - for an individual (who is yourself or your spouse or child) because that individual becomes covered under Medicare or Medicaid.
- you are electing continuation coverage (i.e., COBRA coverage) under the Company's health plan for your spouse or child.

Whether you are able to add or drop coverage under the Company's health plan (and whether continuation coverage will be provided) is determined by the terms of the Company's health plan, not this Plan. This Plan merely provides that, if you are able to change coverage under the health plan and the new coverage results in a change in your premiums, then you can change your election under the Plan to pay the new premium amount with pre-tax dollars. Your change in election under this Plan must be made within 30 days of the court order or the gain/loss of coverage under the other plan.

You also may be able to make a change in election during a Coverage Year if your spouse or child are covered by a plan that has a different annual enrollment period than the Plan. For example, if your spouse or child makes an election under their plan during their plan's annual enrollment period, you can make a corresponding change under the Plan. A change in election during a Coverage Year also is allowed if your spouse or child makes any change under their plan, that would be allowed under the Plan, and your change is consistent with your spouse's or child's change. In either case, you must inform the Company of your change within 30 days after your spouse or child makes their election or change in election under their plan. A change to your election for medical expense reimbursement benefits is not allowed under these circumstances.

If one of the events described above occurs and you are able to make a change in election during a Coverage Year, but you do not inform the Company of the change within the required time period (i.e., 30 days), your change will not be allowed. If your change is made within the required time period, your change will be effective as soon as administratively possible following the date you notify the Company of the change. However, if your change involves adding coverage for a newborn or adopted child under the Company's health plan and the health plan provides for retroactive coverage back to the date of the birth/adoption, your change in election under the Plan will be effective as of the date coverage under the health plan was effective.

In certain cases, the Company can change your election during a Coverage Year. If there is an increase (or decrease) in the cost of coverage you elected under one or more of the Covered Programs, the Company may elect to increase (or decrease) the amount of pre-tax dollars withheld from your wages to pay for your elected coverage. Also, if you are a highly-compensated officer of the Company or you are a member of the "highly paid" group of employees (as defined by federal tax law), the Company may reduce the amount of pre-tax dollars withheld from your pay if necessary to prevent the Plan from being discriminatory (as defined by federal tax law).

2.5 How do I receive benefits that I elect under the Plan?

If you elect benefits under the Plan, an account ("Account"), which may consist of two or more sub-accounts (depending on the number of benefits that you choose), will be established for record-keeping purposes only to keep a record of the benefits to which you are entitled. Your Account is increased by the amount of pre-tax dollars that are withheld from your wages and/or Company contributions made on your behalf. Your Account is reduced by benefits that are paid to you or on your behalf. No interest or other earnings will be added to your Account at any time.

Pre-tax premium payments that you elect to pay through the Plan are automatically deducted from your Account and used to pay your portion of the premiums for coverage that you elected under one or more Covered Programs. (See Answer 3.2 for the definition of Covered Program.) The coverage or benefits provided under a Covered Program are provided pursuant to the terms of that Covered Program. If you believe you are entitled to coverage or benefits under a Covered Program, you must refer to the terms of that Covered Program and follow its required procedures for making a claim for benefits.

To receive reimbursement of eligible medical or dependent care expenses, you must submit a claim to the Administrator within the time period set forth in Answer 2.6. To be reimbursable, eligible expenses must have been incurred during the Coverage Year for which the benefit was elected. You may not be reimbursed for any expense arising before the Plan or your enrollment became effective, or for any expenses incurred after the close of the Coverage Year. To receive reimbursement of your eligible dependent care expenses, your claim must include the names and taxpayer identification numbers of any persons who provided you with dependent care services for which you are seeking reimbursement.

2.6 When must I submit claims for reimbursement of eligible expenses?

You may submit claims to the Administrator on an ongoing basis through the Coverage Year, but must submit all claims prior to the 90th day following the end of the Coverage Year in which the eligible expenses were incurred. You do not have to actually pay an amount before you receive reimbursement. Once you incur an eligible expense, you can submit a claim. You also can submit a claim if you feel you are not receiving benefits to which you are entitled. The Administrator will review your claim and determine whether your claim should be granted. The Administrator will notify you of its decision within 30 days after receiving your written claim. In certain cases, the Administrator may take up to an additional 15 days (for a total of 45 days) to review your claim. If the Administrator needs additional time to review your claim, you will be notified in writing within the initial 30-day period. If the extension is needed because you have not given the Administrator information it needs to review your claim, then the time period for the Administrator to review your claim may be suspended (i.e., not run) until you provide the requested information.

2.7 What amounts will be available to pay my claims for reimbursement?

For medical expense reimbursements, the amount that you elected to contribute for medical expense reimbursements for the Coverage Year (minus any reimbursements you already received) will be available to pay your claims. For dependent care reimbursements, the amount available to pay your claims is the amount that you have actually contributed to the Plan for dependent care reimbursements (minus any reimbursements you already received). If your current dependent care sub-account balance is not sufficient to pay your claim in full, the portion not paid will be carried over into following months during the Coverage Year to be paid when (and if) your account balance becomes adequate to pay the claim.

2.8 What happens if my claim for reimbursement is denied?

If your claim is denied by the Administrator, you will receive a written or electronic notice explaining why your claim was denied. If additional information is needed, the notice will describe the information that is needed and will explain why it is needed. The notice will explain your right to request a review of the claim denial and your right to bring a civil action if you request a review and your claim continues to be denied on review. If the Administrator relied upon an internal rule or guideline in denying your claim, the notice will tell you this and will tell you that you have the right to request a free copy of the rule or guideline. If the Administrator's denial is based on medical necessity or experimental treatment or a similar exclusion or limit, the notice will tell you this and will tell you that you have the right to a file copy of the explanation.

If your claim is denied by the Administrator, you can request a review of the denial as described below. If you do not timely request a review, the denial will be final, binding, and nonappealable. Your request for a review must be made in writing to the Administrator within 180 days after you receive the Administrator's written or electronic notice of denial. If you request a review within this time period, the Administrator will review the claim and the denial and, after a full and fair review, determine whether your claim should continue to be denied. The review will be done by someone other than the person (or subordinate of the person) who decided your claim in the first case. If the Administrator's denial was based in whole or in part on medical judgment, the Administrator will consult with a health care professional who has appropriate training and experience.

As part of the review, you have the right to submit written comments, documents, records and other information relating to your claim. You also have the right to request copies of any records or other information relevant to your claim. These copies will be provided to you free of charge. If the Administrator received advice from medical or vocational experts in reviewing your claim, the identity of these experts will be disclosed to you, even if the Administrator did not rely upon the advice in deciding your claim. If the Administrator's denial was based in whole or in part on medical judgment, in reviewing your claim, the Administrator will consult with a qualified health care professional. In reviewing your claim and the Administrator's denial of your claim, the Administrator will consider all information that you give to the Administrator, whether or not the Administrator reviewed the information in deciding your claim in the first instance.

The Administrator will notify you of its decision within 60 days after the Administrator receives your written request for review. If your claim is denied on review, you will receive a written or electronic notice, explaining why your claim was denied. The notice will explain your right to receive, upon request and free of charge, copies of any documents and other information relevant to your claim. The notice also will explain your right to bring a civil action. If the Administrator relied upon an internal rule or guideline in denying your claim, the notice will tell you this and will tell you that you have the right to request a free copy of the rule or guideline. If the Administrator's denial is based on medical necessity or experimental treatment or a similar exclusion or limit, the notice will tell you this and will tell you that you have the right to request a free copy of the explanation.

2.9 Will my unused year-end account balance be carried over to the next Coverage Year?

No. Any unused amounts credited to your Account as of the end of the Coverage Year will be forfeited if you have not submitted a claim for eligible expenses (incurred during the Coverage Year) prior to the 90th day following the end of the Coverage Year.

2.10 May I withdraw cash from my Account?

No. Your Account may be used only to provide the non-taxable benefits offered under the Plan.

2.11 May I use an amount elected for one benefit for another benefit instead?

No. The amount that you elect for a benefit may only be used for that particular benefit.

2.12 What if I terminate my employment during a Coverage Year?

If your employment with the Company is terminated during a Coverage Year, you will not be able to make any more contributions to the Plan, other than as may be permitted under the continuation coverage provisions described below, which apply to any health care benefits offered and elected under the Plan. You may obtain reimbursements from your Account for eligible expenses incurred by you during the Coverage Year in which your employment terminates. You must comply with the normal requirements for submitting claims for reimbursements. (See Answers

2.5 and 2.6.) Moreover, any reimbursements will be limited to the amount in your Account for the applicable benefit.

If your employment is terminated, you are rehired within 30 days, and you are rehired into a category of employees who are eligible to participate in the Plan, then your participation in the Plan will resume as of your rehire date and you must recommence contributions for the benefits elected under the Plan.

2.13 Will I have any administrative costs under the Plan?

Yes, the Company will charge a portion of the administrative costs to the participants. The administrative fee per pay period will be listed on the annual enrollment form.

2.14 How long will the Plan remain in effect?

Although the Company expects to maintain the Plan indefinitely, the Company has the right to modify or terminate the Plan. If the Plan is terminated, your account balance will be used to provide benefits through the end of the Coverage Year in which termination occurs, or until your account balance is exhausted, whichever occurs first. Also, future changes in state and/or federal tax laws may require that the Plan be amended.

2.15 Are my benefits taxable?

Generally, no. Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan (other than the cash benefit) are not currently taxable to you under present law. However, the Company can not guarantee the tax treatment to any given Participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax advisor.

2.16 What is “Continuation Coverage” and how does it work?

“Continuation Coverage” is generally not applicable to cafeteria plans; however, there are certain instances in which it may be. The applicability of Continuation Coverage is discussed in the plan document. If it does apply, “Continuation Coverage” means your right, or your spouse’s and/or dependents’ right, to continue to participate in the medical expense reimbursement benefit (if offered under the Plan and) if participation by you (including your spouse and dependents) would end due to the occurrence of a “Qualifying Event,” which would make you a “Qualified Beneficiary.” A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours, which results in your no longer meeting the eligibility requirements of the applicable plan and/or benefit;
- your death;
- divorce or legal separation from your spouse;

- your becoming eligible to receive Medicare benefits; or
- when a dependent of yours ceases to be a dependent.

If the Qualifying Event is termination of your employment or reduction of your work hours, the Continuation Coverage period is 18 months. Otherwise, it is 36 months.

It will be your obligation to inform the Administrator of the occurrence of any Qualifying Event, other than a change in your employment status, within 60 days of the occurrence. If Continuation Coverage applies, the Administrator, in turn, has a legal obligation to permit you to elect to continue to participate in the medical expense reimbursement benefit, and you will receive a notice within 45 days of a change of your employment or within 14 days of your notice of the occurrence of any other Qualifying Event. You will then have at least 60 days to elect Continuation Coverage. The amount you will pay will be 102% of your current contribution (per payroll period) for the medical expense reimbursement benefit, and your contribution must be made with after-tax dollars. If Continuation Coverage applies, the notice that you will receive will explain all the rest of the terms and conditions of Continuation Coverage.

PART 3 PRE-TAX PREMIUM BENEFIT

3.1 What is the pre-tax premium benefit?

The pre-tax premium benefit provides you with the opportunity to pay for certain coverage with pre-tax dollars.

3.2 What coverage may be paid for through the Plan?

Through the Plan, eligible employees can pay the portion of any premiums for which they are responsible for the following benefit programs ("Covered Programs") currently offered by the Company: group medical, dental and vision.

3.3 What is the maximum pre-tax premium benefit that I can elect?

For any Coverage Year, the amount of the pre-tax premium benefit that you elect cannot exceed the premium(s) due during the Coverage Year for the Covered Program(s).

3.4 Where can I obtain further information about the benefits provided under the Covered Programs?

For the details regarding eligibility provisions and premium and benefit amounts, please refer to the booklet for each Covered Program, which may be obtained from the Company.

PART 4

MEDICAL EXPENSE REIMBURSEMENT BENEFIT

4.1 What is the medical expense reimbursement benefit?

The medical expense reimbursement benefit provides you with the opportunity to elect to receive income tax-free reimbursement for some or all of your eligible, medical expenses. Under the Plan, you can purchase a specific dollar amount of medical expense reimbursement benefits with pre-tax dollars.

4.2 What is the maximum medical expense reimbursement benefit that I can elect?

For any Coverage Year, you cannot elect to receive more than \$2,000 in medical expense reimbursement benefits.

4.3 What is an “eligible medical expense”?

Generally, an “eligible medical expense” is any item for which you could have claimed a medical care expense deduction on an itemized federal income tax return for which you have not otherwise been reimbursed from insurance or some other plan or program. You are encouraged to consult your personal tax advisor for further guidance as to what is or is not an eligible expense if you have any doubts. You also may consult IRS Publication 17 “Your Federal Income Tax”, but you should note that not all deductible items are reimbursable. For example, premium payments are deductible, but they are not reimbursable as an “eligible medical expense.” Also, certain over-the-counter drugs may be reimbursable as an “eligible medical expense” even if they are not deductible. To be reimbursable, the over-the-counter drug must be needed for medical treatment (for example, allergy medication to alleviate allergies) and not used for general health (for example, dietary supplements, such as vitamins), and you may be required to certify that the drug is needed for medical treatment.

4.4 What if the medical expenses that I incur during the Coverage Year are less than the annual benefit I elected?

You will not be entitled to receive any direct or indirect payment or refund that represents the difference between your actual medical expenses for the Coverage Year and the annual benefit you elected and paid for. The difference, if any, will be forfeited.

PART 5 DEPENDENT CARE REIMBURSEMENT BENEFIT

5.1 What is the dependent care reimbursement benefit?

The dependent care reimbursement benefit provides you with the opportunity to elect to receive tax-free reimbursement for some or all of your eligible dependent care expenses. Under the Plan, you can purchase a specific dollar amount of dependent care reimbursement benefits with pre-tax dollars.

5.2 What is the maximum dependent care reimbursement benefit that I may elect?

You may elect up to \$5,000 per taxable year (no less than \$300) if you –

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free dependent care reimbursements, your spouse maintains a separate residence for the last six (6) months of the calendar year, and you file a separate tax return; or
- are single, or a head of household for tax purposes.

If you are married and reside with your spouse, but file a separate federal income tax return, the maximum dependent care reimbursement benefit you may elect is \$2,500.

In addition to these dollar limitations, the maximum amount of dependent care reimbursement benefits that you may exclude from income during any calendar year cannot be more than C

- If you are not married as of the end of the year, your earned income for the year, or
- If you are married at the end of the year, the lesser of your earned income for the year, or your spouse's earned income. If your spouse is a full time student or is disabled, your spouse is considered under the federal tax rules as if he/she has a monthly earned income of \$200 (if Plan benefits are provided for only one dependent), or \$400 (if Plan benefits are provided for two or more dependents).

5.3 What is an “eligible dependent care expense”?

In general, an “eligible dependent care expense” is an expense for which you have not otherwise been reimbursed from insurance or some other source that you incur to enable you to be gainfully employed and which is incurred for the care of an individual in your family who is either (1) under age 13, and whom you could claim as a dependent on your federal income tax return or (2) your dependent or spouse who is mentally or physically unable to care for himself or herself. You are encouraged to consult your personal tax advisor or IRS Publication 17 “Your Federal Income Tax” for further guidance as to what is or is not an eligible expense if you have any doubts.

5.4 What if the dependent care expenses that I incur during the Coverage Year are less than the annual benefit I elected?

You will not be entitled to receive any direct or indirect payment or refund that represents the difference between your actual dependent care expenses for the Coverage Year and the annual benefit you elected and paid for. The difference, if any, will be forfeited.

5.5 What is the household and dependent care credit and how does my electing dependent care reimbursement benefits affect that credit?

The household and dependent care credit is a credit that you may be able to take on your individual income tax return for dependent care expenses. However, you cannot claim a credit for expenses that you have reimbursed under the Plan since those reimbursements are made on a pre-tax basis.